MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6255 (16245) Reg. Dist. No. 195

1. PLACE OF DEATH
a. COUNTY: HOWARD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ilchester R7 K0 — c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MISSION RD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JESSUP (RURAL)
d. STREET ADDRESS: MISSION RD. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHERINE — Middle MARY — Last BROSENNE

4. DATE OF DEATH: Month 6 — Day 24 — Year 1956

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 9/7/1881 — 9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Domestic — 11. BIRTHPLACE (State or foreign country): MARYLAND — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PATRICK F. HINES ARTHUR A. BROSENNE — 14. MOTHER'S MAIDEN NAME: ELIZABETH DONOHUE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: FREDERECK BROSENNE — Address: 136 S. CULVER BALTIMORE-29, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 6-56

DUE TO (b): Carcinoma Intestinal - Ulcers — 1 mos - 56

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Myo - Coronary Occlusion — —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/5, 19 5_, to 6-24, 19 56, that I last saw the deceased alive on 6/24, 19 56, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: N B Steward M.D. — ADDRESS (Street, city or town, state): Laurel Md — DATE SIGNED

PHYSICIAN'S NAME (Type): N B Steward

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 6/27/56 — 22c. NAME OF CEMETERY OR CREMATORY: ST. JOHNS CEM — 22d. LOCATION (City, town, or county) (State): ELLICOTT CITY, MD

23. FUNERAL DIRECTOR'S SIGNATURE: Easton Sons — ADDRESS: Catonsville Md — 24a. REC'D BY REGISTRAR DATE: 6/26/56 — 24b. REGISTRAR'S SIGNATURE: Frank Shipley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6256

06247

Reg. Dist. No. 797

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Taylor Manor Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville
03-52-2
d. STREET ADDRESS: 312 Montrose Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie — Middle: Burgus — Last: Crabson

4. DATE OF DEATH: Month: June — Day: 10 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1885

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Balto Co, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John S. Graser

14. MOTHER'S MAIDEN NAME: Emma —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT — Address: Mr. George W. Crabson - 312 Montrose Ave. 28

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
332X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X
(b): Cerebral thrombosis — 8 mos.
DUE TO
(c): Generalized arteriosclerosis — yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 19, 1956, to June 10, 1956, that I last saw the deceased alive on June 10, 1956, and that death occurred at 6:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Irving J. Taylor M.D.
ADDRESS (Street, city or town, state): Taylor Manor Hospital
DATE SIGNED: 6/10/56

PHYSICIAN'S NAME (Type): Irving J. Taylor, M.D.
Ellicott City, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/13/56
22c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem.
22d. LOCATION (City, town, or county) (State): Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR — DATE: 6-13-56
24b. REGISTRAR'S SIGNATURE: John B. Bughman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6257

08366

Reg. Dist. No. 19/

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GEORGE Middle CLARENCE Last EDWARDS

4. DATE OF DEATH: Month June Day 21 Year 1956

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]: Unknown

8. DATE OF BIRTH: Nov. 19, 1892

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Day worker

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): W W 1
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-10-5801

17. INFORMANT Address: Rachel Bruce, Clarksville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: George E. Burgtorf M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: June 21, 1956.

EXAMINER'S NAME (Type): George E. Burgtorf M.D.

22a. ~~BURIAL, CREMATION, REMOVAL~~ (Specify): Entombment

22b. DATE THEREOF: 6/22/56

22c. ~~NAME OF CEMETERY OR CREMATORY~~: U. of Md. Med. School

22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

24a. REC'D BY REGISTRAR DATE

24b. REGISTRAR'S SIGNATURE: John B. Langhram

E.J.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06248

6258

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Harford Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b: 14 mos.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Taylor Manor Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 4305 Ridgewood Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Isaac — Middle — Last Goodman

4. DATE OF DEATH: Month JUN — Day 6 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7 FEBb 1882

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Newyork N.Y

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: David

14. MOTHER'S MAIDEN NAME: Rebecca

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wor or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Ida Goodman - same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 332X — Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b): Cerebral Arteriosclerosis — years
DUE TO
(c): Generalized arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hemi-balismus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 22, 19 55 to 6 JUN, 19 56 that I last saw the deceased alive on 6 JUN, 19 56, and that death occurred at 2:00 a.m. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Irving J. Taylor M.D. — ADDRESS (Street, city or town, state): Ellicott City, Md. — DATE SIGNED: 6 JUN 56

PHYSICIAN'S NAME (Type): Irving J. Taylor, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-7-56

22c. NAME OF CEMETERY OR CREMATORY: Druan Israel

22d. LOCATION (City, town, or county) (State): Balto. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Jack Lewis Inc — ADDRESS: 2100 Eutaw Place

24a. REC'D BY REGISTRAR DATE: JUN 8 1956

24b. REGISTRAR'S SIGNATURE: John L Loughran

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06249

6259

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Mt. Airy
c. LENGTH OF STAY IN 1b: 7 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route 3 - Mt. Airy

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy - Rural
d. STREET ADDRESS: Route 3 - Mt. Airy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma; Middle: Elizabeth; Last: Grove

4. DATE OF DEATH: Month: June; Day: 22; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 1, 1863

9. AGE (In years last birthday): 92 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Clay

14. MOTHER'S MAIDEN NAME: Caroline Keifer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. Zourie Michael
Address: 1005 Savannah St. S.E. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra Abdominal Malignancy
153X
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Unknown (Discovered Feb. 56)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February, 1956, to June, 1956, that I last saw the deceased alive on June 18, 1956, and that death occurred at 10:50 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W.B. Culwell M.D.
ADDRESS (Street, city or town, state): Mount Airy, Maryland
DATE SIGNED: 6/22/56
PHYSICIAN'S NAME (Type): W.B. Culwell

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-25-1956
22c. NAME OF CEMETERY OR CREMATORY: Friendship
22d. LOCATION (City, town, or county) (State): Morgan Co. W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: E.M. Watts
ADDRESS: Winfield. Md.

24a. REC'D BY REGISTRAR DATE: JUN 25 1956
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be used for use as the burial-transit permit. Then please remove carbon papers.

VS A1S (4)
1SM 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6260 — 06250

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Frederick Road

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Florida
b. COUNTY: Dade
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Miami
d. STREET ADDRESS: 149 93rd St. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALPHA Middle N Last HERBERT

4. DATE OF DEATH: Month June Day 22 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 17, 1900

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10b. KIND OF BUSINESS OR INDUSTRY: City of Miami

11. BIRTHPLACE (State or foreign country): Oakhurst N.J.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas F. Herbert

14. MOTHER'S MAIDEN NAME: Jennie King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Beatrice Herbert, Miami, Florida — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RUPTURE OF ARTERIOSCLEROTIC
DUE TO (b): ANEURYSM OF ABDOMINAL AORTA — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (c):

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: George E. Burgtorf M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-22-56

EXAMINER'S NAME (Type): George E. Burgtorf

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/25/56
22c. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE
22d. LOCATION (City, town, or county) (State): DORSEY MD

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: E. C. HIGINBOTHAM, ELLICOTT CITY, MD
24a. REC'D BY REGISTRAR DATE: June 23, 56
24b. REGISTRAR'S SIGNATURE: John B. Laughran, Jr. B. E. L.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6261 06251

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Shaffer's Convalescent Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 V 01-4
d. STREET ADDRESS: 2307 Harlem Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle B. — Last JOYNER
4. DATE OF DEATH: Month June — Day 9, — Year 1956

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 31, 1871
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Jewelry
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Joyner
14. MOTHER'S MAIDEN NAME: Alice Turnage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-09-8581A
17. INFORMANT — Address: Mrs. Anna N. Joyner - 2307 Harlen Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 0
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 6, 1956, to June 9, 1956, that I last saw the deceased alive on June 6, 1956, and that death occurred at 3 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George E. Burgtorf M.D. — ADDRESS (Street, city or town, state): Ellicott City, Md — DATE SIGNED: 6/11/56

PHYSICIAN'S NAME (Type): George E. Burgtorf, M. D. — Ellicott City, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/12/56
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
22d. LOCATION (City, town, or county) (State): Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Pickens & Sons - Baltimore, Md — ADDRESS
24a. REC'D BY REGISTRAR — DATE: 6-13-56
24b. REGISTRAR'S SIGNATURE: John H. Loughran

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06252

6262 CERTIFICATE OF DEATH

Reg. Dist. No. 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY: Howard — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): Ellicott City

LENGTH OF STAY (in this place): 2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Church Rd. Highland Manor Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 3V01-4

STREET ADDRESS (If rural give location): 27 E. Cross St.

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) (Last) Kern

4. DATE OF DEATH: (Month) June (Day) 18 (Year) 19 56

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Sept. 27, 1883

9. AGE last birthday: 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Tavern Operator-Self-Employed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin Manning

14. MOTHER'S MAIDEN NAME: ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) none

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Albert Clayland-Son-27 E. Cross St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

443X

Immediate cause — (a) Myocardial insufficiency

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Arteriosclerosis - Hypertension

DUE TO

(c) Myocarditis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June 15, 19 56, to June 18, 19 56, that I last saw the deceased alive on June 15, 19 56, and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE (Degree or title): Julius Schweinsberg M.D. — ADDRESS: 1337 S. Charles St Balto 30. Md — DATE SIGNED: 6/18/56

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial

DATE THEREOF: June 20/56

NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

LOCATION (City, town, or county) (State): Ritchie Highway Md.

DATE REC'D BY LOCAL REGISTRAR: 6-19-56

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: SCHWEINSBERG FUNERAL SERVICE 1126 W. Cross St. Balto. 30 Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06253

6263

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Howard MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 195

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover (Rural)
STREET ADDRESS (If rural give location) Box 195

3. NAME OF DECEASED: (Type or Print) (First) Ernestine (Middle) Wilhelmina (Last) Lang

4. DATE OF DEATH: (Month) June (Day) 2 (Year) 1936

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 2-1892
9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Keeper
10B. KIND OF BUSINESS OR INDUSTRY: Grocery Store
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Yourst
14. MOTHER'S MAIDEN NAME: Minnie Brunk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 218-32-4667
17. INFORMANT & ADDRESS: Alfred A Lang (Husband) Box 195, Hanover Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 X

IMMEDIATE CAUSE (A) Apoplexy. — 15 min

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arterial Hypertension — 3 yrs

DUE TO (C) General Arterio sclerosis — 3 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 1st Stroke — May 31/34

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 31, 1936, to June 2, 1936, that I last saw the deceased alive on June 1, 1936, and that death occurred at 3 30 a. M, from the causes and on the date stated above.

SIGNATURE M. D. Dr. B.B. Brumbaugh
ADDRESS 5609 Main St Eldridge 27 Md
DATE SIGNED 6/2/36

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 6/5/56
NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.
LOCATION (City, town, or county) (State) Elkridge, Md.

DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Wm. J. Pickerel & Sons
ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

A34

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G200 7-19-56 et

6264

06254

CERTIFICATE OF DEATH

Reg. Dist. No. 19 C

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Howard MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge Rural
LENGTH OF STAY (in this place) yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Duckett Lane

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Howard
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge Rural
STREET ADDRESS (If rural give location) Duckett Lane

3. NAME OF DECEASED: (Type or Print) (First) William H (Middle) (Last) Madden

4. DATE OF DEATH: (Month) June (Day) 5 (Year) 1956

5. SEX: Male

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Aug. 8 1877

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Elkridge Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Madden

14. MOTHER'S MAIDEN NAME: Harriet ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Martha Madden (wife) Elkridge Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE (A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 2 Mos

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypocongestion — 5 Yrs

DUE TO (C) Arterial Hypertension — 5 Yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1956 to June 5, 1956, that I last saw the deceased alive on June 5, 1956, and that death occurred at 5-8, M, from the causes and on the date stated above.

SIGNATURE M. D. Dr. B. B. Baumgaugh

ADDRESS 3609 Main St Elkridge 27 Md

DATE SIGNED 6/5/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 6-8-56

NAME OF CEMETERY OR CREMATORY Mt Auburn

LOCATION (City, town, or county) (State) Baltimore Md

DATE REC'D BY LOCAL REGISTRAR 6-7-56

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Elroy D. Wilson

ADDRESS 1000 Broadway

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06255

6265

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH
a. COUNTY: HOWARD COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLARKSVILLE, MD. (RURAL)
c. LENGTH OF STAY IN 1b: MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COLLEGE PARK, MARYLAND
d. STREET ADDRESS: 9508-49th PLACE, COLLEGE PARK, MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16-14-2

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
PATRICIA	ANN	McGOWAN	JUNE	9th,	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
FEMALE	WHITE		10/6/1955	0 yrs.	8	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
———	NONE.....	WASHINGTON, D.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ARTHUR J. McGOWAN	JEAN L. McGOWAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address: COLLEGE PARK, MD.
NO.		MR. ARTHUR J. McGOWAN (FATHER) 9508-49th PLACE,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Marasmus — INTERVAL BETWEEN ONSET AND DEATH: 2 months

759.3

DUE TO (b): Spina bifida, meningocele, hydro-cephalus — congenital

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from March 2, 1956, to June 9, 1956, that I last saw the deceased alive on June 7, 1956, and that death occurred at 6:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whittaker, M.D. — ADDRESS (Street, city or town, state): CLARKSVILLE, MARYLAND — DATE SIGNED: 6/9/1956

PHYSICIAN'S NAME (Type): DR. WHITTAKER, M.D. — CLARKSVILLE, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	6/11/1956	ST. MARYS CATHOLIC CEMETERY	WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
MARTIN W. HYSONG COMPANY 1300 N. STREET, N.W. WASH. D.C.	6-11-56	Marie G. Whittaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6266

06256

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Friendship

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route 144

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Friendship

d. STREET ADDRESS: Route 144

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: AMBROSIA — Middle: H. — Last: OSTER

4. DATE OF DEATH: Month: June — Day: 16 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 23, 1883

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Carden, Indiana

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Hurst

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Philip Oster, West Friendship, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

592X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 260X

DUE TO (b): NEPHROSCLEROSIS — 2 YEARS

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITIS 20 YRS

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/18, 1942, to 6/16, 1956, that I last saw the deceased alive on 6/15, 1956, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whitaker M.D.

ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): CHARLES S. WHITAKER, M.D. CLARKSVILLE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-19-56

22c. NAME OF CEMETERY OR CREMATORY: Mc Kendree

22d. LOCATION (City, town, or county) (State): West Friendship

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F.C. Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: 6-18-56

24b. REGISTRAR'S SIGNATURE: Mari A. Whitaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

A34

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6267

CERTIFICATE OF DEATH

Reg. Dist. No. 06257

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Glenwood
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Glenwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MARGARET Middle E Last YOUNG

4. DATE OF DEATH: Month June Day 6 Year 1956

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/25/1877

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abraham Porter

14. MOTHER'S MAIDEN NAME: Unk —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ben Young — Address: Glenwood, Md. Son.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure, Coronary thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 11 Feb 56
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): arteriosclerotic heart disease. — 6 June 56
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1956 to June, 1956, that I last saw the deceased alive on 16 May, 1956, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E Hall M.D.
ADDRESS (Street, city or town, state): Ilchesville, Md
DATE SIGNED: 6 June 56

PHYSICIAN'S NAME (Type): HOWARD E. HALL MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/10/56
22c. NAME OF CEMETERY OR CREMATORY: Bushy Park
22d. LOCATION (City, town, or county) (State): Dorsville, Howard, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Furtick
ADDRESS: Hillcrest Heights, Lyksville, Md.

24a. REC'D BY REGISTRAR DATE: 6-11-56
24b. REGISTRAR'S SIGNATURE: A. W. Hedrick Jr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55